Complete Summary

GUIDELINE TITLE

Oropharyngeal cancer.

BIBLIOGRAPHIC SOURCE(S)

Oropharyngeal cancer. Philadelphia (PA): Intracorp; 2005. Various p. [25 references]

GUIDELINE STATUS

This is the current release of the guideline.

All Intracorp guidelines are reviewed annually and updated as necessary, but no less frequently than every 2 years. This guideline is effective from April 1, 2005 to April 1, 2007.

COMPLETE SUMMARY CONTENT

SCOPE
METHODOLOGY - including Rating Scheme and Cost Analysis
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IDENTIFYING INFORMATION AND AVAILABILITY
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SCOPE

DISEASE/CONDITION(S)

Oropharyngeal cancer

- Squamous cell carcinoma
  - Non-keratinizing
  - Keratinizing
  - Verrucous
  - Spindle cell
  - Adenoid squamous carcinoma
- Adenoid cystic carcinoma or other salivary gland carcinoma
- Lymphoma

GUIDELINE CATEGORY

Diagnosis
Evaluation
Management
Treatment

CLINICAL SPECIALTY

Family Practice
Internal Medicine
Oncology
Otolaryngology
Radiation Oncology
Surgery

INTENDED USERS

Allied Health Personnel
Health Care Providers
Health Plans
Hospitals
Managed Care Organizations
Utilization Management

GUIDELINE OBJECTIVE(S)

To present recommendations for the diagnosis, treatment, and management of oropharyngeal cancer that will assist medical management leaders to make appropriate benefit coverage determinations

TARGET POPULATION

Individuals with oropharyngeal cancer

INTERVENTIONS AND PRACTICES CONSIDERED

Diagnosis/Evaluation

1. Physical examination and assessment of signs and symptoms
2. Diagnostic tests:
    - Direct and indirect laryngoscopy
    - Nasopharyngoscopy
    - Biopsy
    - X-rays, including chest x-rays (CXR)
    - Computerized tomography (CT) or magnetic resonance imaging (MRI) in selected patients
    - Liver function studies

Management/Treatment

1. External beam therapy prior to surgery
2. Surgery - wide excision of tumor
3. Radiation therapy
4. Chemotherapy
5. Combination of any or all of the above modalities
6. Reconstruction
7. New therapies, such as biologics (vaccines, growth factor-receptor antagonists, cyclin-dependent kinase inhibitors, oncolytic viruses) and photodynamic therapy (under clinical investigation)
8. Physical therapy if indicated
9. Referral to specialists
10. Case management strategies, including case initiation, case management focus, and discharge

MAJOR OUTCOMES CONSIDERED

Risk factors for oropharyngeal cancer

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

Hand-searches of Published Literature (Primary Sources)
Hand-searches of Published Literature (Secondary Sources)
Searches of Electronic Databases

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

Searches were performed of the following resources: reviews by independent medical technology assessment vendors (such as the Cochrane Library, HAYES); PubMed; MD Consult; the Centers for Disease Control and Prevention (CDC); the U.S. Food and Drug Administration (FDA); professional society position statements and recommended guidelines; peer reviewed medical and technology publications and journals; medical journals by specialty; National Library of Medicine; Agency for Healthcare Research and Quality; Centers for Medicare and Medicaid Services; and Federal and State Jurisdictional mandates.

NUMBER OF SOURCE DOCUMENTS

Not stated

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Weighting According to a Rating Scheme (Scheme Not Given)

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

Not stated

METHODS USED TO ANALYZE THE EVIDENCE

Review

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

Not stated

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Expert Consensus (Delphi)

DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS

A draft Clinical Resource Tool (CRT or guideline) is prepared by a primary researcher and presented to the Medical Technology Assessment Committee or the Intracorp Guideline Quality Committee, dependent upon guideline product type.

The Medical Technology Assessment Committee is the governing body for the assessment of emerging and evolving technology. This Committee is comprised of a Medical Technology Assessment Medical Director, the Benefit and Coverage Medical Director, CIGNA Pharmacy, physicians from across the enterprise, the Clinical Resource Unit staff, Legal Department, Operations, and Quality. The Intracorp Guideline Quality Committee is similarly staffed by Senior and Associate Disability Medical Directors.

Revisions are suggested and considered. A vote is taken for acceptance or denial of the CRT.

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

Not applicable

COST ANALYSIS

A formal cost analysis was not performed and published cost analyses were not reviewed.

METHOD OF GUIDELINE VALIDATION

Comparison with Guidelines from Other Groups
Internal Peer Review

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

Not stated

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

Diagnostic Confirmation

Subjective Findings

- Mouth, ear, and/or jaw pain
- Bleeding
- Difficulty swallowing
- Presence of a lump or sore in mouth or throat
- Swelling under the chin or around the jaw bone
- Hoarseness, change in speech quality
- Frequent headaches
- Cough
- Weight loss (a late symptom)

Objective Findings

- Visible, palpable mass on physical exam
- Unilateral or bilateral cervical lymphadenopathy
- Ulceration
- Otalgia
- Odynophagia and/or dysphagia
- Leukoplakia (whitish plaque)
- Erythroplasia (innocuous-appearing red, atrophic lesion that stains with toluidine blue)
- Irritated nasal passages (may be associated with prolonged exposure to wood dust, nickel dust, asbestos, or other airborne particles)
- Hemoptysis

Diagnostic Tests

- Laryngoscopy, direct and indirect
    - Direct examination under general anesthesia is the primary method for larynx evaluation to visually determine the extent of tumor and to obtain biopsies especially if submucosal lesions are present
- Nasopharyngoscopy
    - Direct visualization through the nose of the nasal cavity and nasopharynx
    - Esophagoscopy may be indicated to allow for identification of possible synchronous tumors
- Biopsy
    - Biopsy on any suspicious lesion is absolutely necessary prior to therapy initiation to confirm the diagnosis and determine the extent of disease
- X-rays, including chest x-ray (CXR) (see the Intracorp Imaging guidelines)
    - X-rays, including CXR, are used to discover and evaluate lesion extent in head and neck tumors invading the larynx and oropharyngeal cancers

    - Computerized tomography (CT) or magnetic resonance imaging (MRI) may be useful in selected patients
        - MRI to evaluate soft tissues; particularly at base of tongue, parapharyngeal space
        - CT to evaluate bony invasion at base of skull, mandible
- Laboratory values
    - Liver function studies to screen for metastasis

Differential Diagnosis

- Acute irritation (burns or trauma)
- Chronic irritation (from teeth, dental appliances, pipes, mouthwash with a high alcohol content, etc.)
- Lichen planus
- Nicotine mucositis
- Lymphoid hyperplasia
- Laryngeal cancer (see the Intracorp guideline Laryngeal Cancer)
- Infections (Candida)
- Leukoplakia

Treatment Options

- External beam therapy prior to surgery
    - Care Setting: clinic or free-standing outpatient facility; may be delivered in acute inpatient or subacute setting if patient airway compromised, severely deconditioned, etc.
- Surgery - wide excision of tumor
    - Transoral approach when possible;
    - Mandibular or transcervical transpharyngeal approaches may be necessary.
    - Neck dissection has high associated morbidity and efficacy may be questionable; current trends favor radiation or chemoradiation therapy, especially in advanced disease.
    - Care Setting: acute inpatient
- Radiation therapy
    - Care Setting: clinic or free-standing outpatient facility; may be delivered in acute inpatient, subacute/skilled nursing facility inpatient, or hospice inpatient setting if patient airway compromised, severely deconditioned, etc.
- Chemotherapy (see the Intracorp guideline Chemotherapy)
    - Care Setting: clinic or free-standing outpatient, physician's office, or home care; may be delivered in an acute inpatient, subacute/skilled nursing facility inpatient, or hospice inpatient setting if patient airway compromised, severely deconditioned, etc.
- Regimes that combine any or all of the above modalities
- Reconstruction
    - Mediate functional compromise/loss
    - Minimize severe disfigurement
- New therapies under clinical investigation; safety and efficacy HAVE NOT been established
    - Biologics - vaccines, growth factor-receptor antagonists, cyclin-dependent kinase inhibitors, oncolytic viruses

- Photodynamic therapy

Duration of Medical Treatment

- Medical - Optimal: 7 day(s), Maximal: 49 day(s)
    - Advanced disease may require lifetime care

Additional information regarding primary care visit schedules, referral options, specialty care, physical therapy, and durable medical equipment is provided in the original guideline document.

The original guideline document also provides a list of red flags that may affect disability duration, and return to work goals, including

- After surgical excision of lesion
- Radiation therapy
- Surgical excision of lesion
- After laryngectomy, other extensive surgery

Note: Some patients with this condition may never return to work

Case Management Directives (refer to the original guideline for detailed recommendations)

Case Initiation

Establish Case

- Document baseline information, history, key physical findings, patient's understanding, and safety factors.
- See Chemotherapy Chart in the original guideline document.
- The American Joint Committee on Cancer encourages use of the "TNM" classification system (T=primary tumor size; N=lymph node involvement; M=metastasis).
- Provide contact information for local and national support groups.

Coordinate Care

- Advocate for patient by managing utilization and charges.
- Document treatment plan.

Case Management Focus

Activity Deficit

- Document patient's degree of literacy (both reading and visual capacities), and the special challenges created regarding communication.
- Evaluate need for speech therapist (ST) in clinic or in home setting.
- Document activity alteration as none, mild, moderate, severe, dependent, or bed-bound (based on most recent performance status) and interventions required.

Chemotherapy Intolerance

- Assess status, acute versus chronic, of toxic side effects on rapidly growing tissues, including bone marrow, epithelium, hair, sperm, and document intervention recommended.

Hemodynamic Instability

- Document bleeding complications, severity, and intervention recommended.

Immune Compromised

- Document establishment of protective isolation measures for a white blood cells count (WBC) less than 1,000/mm^3, implying dangerous susceptibly to infection.

Inadequate Nutrition

- Assess the frequency and need of nursing interventions for swallowing and nutritional support according to the type of surgery performed.
- Assess ability to resume oral intake (solid or liquid) 10 to 14 days after surgery.
- Document alternative route of nutrition and hydration plus duration for nasogastric (N/G) (or gastric tube) enteral feedings, intravenous (IV) fluids, or total parenteral nutrition (TPN) solutions.
- Advise patient experiencing post-surgical altered sense of taste and smell that the olfactory senses usually accommodate with time.
- Use optimal goal of remaining within 10% of pretreatment weight to document hydration and nutrition deficit as mild, moderate, severe and response needed.

Mental and Emotional Alteration

- Ensure accurate diagnosis of any change in mental status.
- Document baseline or optimal mental and emotional functioning and their alterations due to cancer presence, comorbidity, surgery, or treatments.
- Assess and respond appropriately to the degree of debility caused by alterations listed in the original guideline through benefit coordination or community resource activation.

Pain Control

- Document optimal pain management by characterizing severity and interventions undertaken to remedy or manage pain.

Oncologic Emergencies

- Immediately report to the surgeon or activate emergency medical technician (EMT) system as required for airway incompetence, breathing difficulties or obstruction; bleeding at surgical site or from suctioning (critical: carotid artery rupture); fistula formation; local infection or sepsis.

- Document presence of or developing oncologic emergencies and report to attending physician, surgeon, or activate EMT system as necessary.

Radiation Intolerance

- Document presence and severity of radiation side effects.
- Initiate early interventions for complications of radiation therapy.

Respiratory Instability

- Expect laryngectomy tube (larger diameter) replacement by tracheotomy tube 3 to 6 weeks after surgery. Tracheostomy tubes (smaller diameter) remain much longer.
- Assess need for air and oxygen humidification associated with frequent coughing and ejection of large amounts of mucus.
- Instruct in adequate tracheostoma airway protection from water, hair sprays, or powders by using loose-fitting bib, mask, or hand over opening.
- Document respiratory deficit as mild, moderate, severe, and dependent, and respiratory rehabilitation enhancement measures.

Skin Integrity Deficit

- Document barriers to rehabilitation involving tracheostomy care, including presence of wound drains and needs for frequent stomal site and tube cleansing and redressing or frequent suctioning.
- Document severity of skin integrity disruption.

Terminal Care

- Document optimal comfort measures and palliative care initiatives.

Discharge

Discharge from Case Management (CM)

- Document return to independence or stabilized functional status and closing conversations with patient, caregiver, physician, pharmacist, and care providers.

CLINICAL ALGORITHM(S)

None provided

EVIDENCE SUPPORTING THE RECOMMENDATIONS

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

The type of supporting evidence is not specifically stated for each recommendation.

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

Appropriate diagnosis, treatment, and management of oropharyngeal cancer that assist medical management leaders to make appropriate benefit coverage determinations

POTENTIAL HARMS

Refer to the Case Management Focus section of the "Major Recommendations" field for information on potential complications and strategies to address them, or refer to the original guideline document.

IMPLEMENTATION OF THE GUIDELINE

DESCRIPTION OF IMPLEMENTATION STRATEGY

An implementation strategy was not provided.

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IOM CARE NEED

Living with Illness

IOM DOMAIN

Effectiveness

IDENTIFYING INFORMATION AND AVAILABILITY

BIBLIOGRAPHIC SOURCE(S)

Oropharyngeal cancer. Philadelphia (PA): Intracorp; 2005. Various p. [25 references]

ADAPTATION

Not applicable: The guideline was not adapted from another source.

DATE RELEASED

1997 (revised 2005)

GUIDELINE DEVELOPER(S)

Intracorp - Public For Profit Organization

SOURCE(S) OF FUNDING

Intracorp

GUIDELINE COMMITTEE

CIGNA Clinical Resources Unit (CRU)
Intracorp Disability Clinical Advisory Team (DCAT)
Medical Technology Assessment Committee (MTAC)
Intracorp Guideline Quality Committee

COMPOSITION OF GROUP THAT AUTHORED THE GUIDELINE

Not stated

FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

Not stated

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GUIDELINE AVAILABILITY

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AVAILABILITY OF COMPANION DOCUMENTS

The following is available:

- Policies and procedures. Medical Technology Assessment Committee Review Process. Philadelphia (PA): Intracorp; 2004. 4 p.
- Online guideline user trial. Register for Claims Toolbox access at www.intracorp.com.

Licensing information and pricing: Available from Intracorp, 1601 Chestnut Street, TL-09C, Philadelphia, PA 19192; e-mail: lbowman@mail.intracorp.com.

PATIENT RESOURCES

None available

NGC STATUS

This NGC summary was completed by ECRI on May 25, 2005. The information was verified by the guideline developer on June 7, 2005.

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